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Occupational Therapy/Physiotherapy/Social Work Community Resources

Background:

The *Occupational Therapy/Physiotherapy/Social Work Community Resources* guide was created to assist occupational therapists, physiotherapists, and social workers navigate resources available in the community.

The Community Resources are categorized, for the purpose of this document, into the following: **Rehabilitation** (Generalized and Specialized), **In-Home Assessment & Consultation**, **Socialization-Engagement-Respite**, **Primary Care**, **Health Management**, **Community Support**, **Indigenous Support**, and **Crisis Support** (please refer to the 'Definitions' section below for definitions of category titles). Note that some resources may be found in more than one category.

Each Program listed in the document includes information about the programs' features, referral criteria/process and website/additional information.

The included community resource information was taken from each program's website and informed by stakeholder feedback.

Definitions *(of Category Title, as listed above)*:

Rehabilitation: provides assessment & time-limited intervention through a single service or coordinated, interprofessional approach to restore or maximize functional abilities; provides the opportunity to learn & practice in a stimulating and supportive environment.

- Generalized – may involve remediation of several impairments or issues with the goal of improving overall function.
- Specialized – specific to one or few impairments or issues that are impacting overall function.

In-Home Assessment & Consultation: provides short-term assessment/intervention in the individual's home with the purpose of maximizing safety and independence in the home environment; may include the provision of follow-up recommendations.

Socialization-Engagement-Respite: provides an opportunity to engage with others through social activities.

Primary Care: provides team-based interdisciplinary care in connection with the individual's primary care provider.

Health Management: provides education on managing health related conditions and chronic diseases.

Community Support: provides assistance to individuals to maintain/develop skills and social connections.

Indigenous Support: supports holistic needs of First Nations, Metis, and Inuit people.

Crisis Support: provides immediate benefit to people in crisis by enabling them to manage stressful experiences more resourcefully.

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Abbreviations:

- NP - Nurse Practitioner
- OT - Occupational Therapist
- PA - Physician Assistant
- PT - Physiotherapist
- RA - Rehabilitation Assistant
- SLP - Speech Language Pathologist
- SW - Social Worker

Please Note:

The *Occupational Therapy/Physiotherapy/Social Work Community Resources* guide may be useful for other health practitioners in addition to occupational therapists, physiotherapists, and social workers. It also may be useful for health practitioners who work in community settings as well as in hospitals.

The *Occupational Therapy/Physiotherapy/Social Work Community Resources* guide is not an exhaustive list of community resources. Please contact **Yessenia Molina** (ymolina2@wrha.mb.ca) to suggest additions and/or edits to the information included in the guide.

The *Occupational Therapy/Physiotherapy/Social Work Community Resources* guide is intended to be used by healthcare professionals and is not intended for the general public.

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REHABILITATION (Generalized)

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Day Hospital	***Riverview Health Centre, Seven Oaks Hospital, St. Boniface Hospital*** Program Features: • short term rehab (6-12 week program) • clients attend on a weekly basis • includes social & recreational programming • may include meals (site-dependent) • transportation may be available for a fee Team Involved: • *(variable by site)* • OT, PT, SW, Recreational Therapists, Dietitians, Nurses, Geriatric Specialists	• adults 65+ • community-dwelling • willing to participate • transportation can be arranged (note: some sites offer transportation, cost is dependent on site) • reasons for referral can include: falls, unexplained decline in function, social isolation, memory loss, behavioural changes, depression, caregiver stress	Day Hospital Referral Form Referrals can be made by health professionals involved in the client's care, from community or from a facility/hospital. The same referral form is used for all sites - the client's address determines which site they attend (exception: francophone clients)	WRHA Geriatric Day Hospital Brochure Informational PPT (from Alzheimer's Society) RHC Day Hospital Website
	Deer Lodge Centre (Comprehensive Geriatric Assessment Clinic) Program Features: • multi-domain assessments & team intervention; includes education & chronic disease management • does not include social/recreational programming, meals, or transportation Team Involved: • OT, PT, SW, SLP, Nurse, Pharmacist, Geriatrician			Comprehensive Geriatric Assessment Clinic Website

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REHABILITATION (Generalized)

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Priority Home Services	Program Features: • provides rehab / restorative services to clients to optimize functioning post-acute hospitalization • support for patients who have been identified as at risk of PCH placement, with a focus on staying home • additional service option within the WRHA Home Care Program • runs for up to 90 days Team Involved: • OT, PT, SLP, SW, RA	• high risk for LTC or urgent PCH placement • high risk/precarious discharge and risk of re-hospitalization, requiring intensive case management • significant functional change and would benefit from allied health involvement • willing to participate and motivated toward rehab • heavy care plan requiring a restorative, collaborative approach to ensure care plan is maintainable for community home care	Referrals are coordinated by the Hospital Based or Community Home Care Coordinator. A Priority Home Services representative may be contacted prior to initiating a referral, to discuss appropriateness for service and/or to attend complex discharge planning meetings. **PHS Intake Case Coordinator:** 204-792-1736	PHS FAQs PHS Website
Safety Aid - Falls Prevention Program *offered by A&O Support Services for Older Adults*	Program Features: • fall prevention program for older adults • assesses & provides interventions for falls risk • consists of a falls risk assessment (in-person), a 24-week exercise program and education (offered virtually), and a home assessment • free for eligible adults Team Involved: • OT, Athletic Therapist, Nurse, Pharmacist, Dietitian	• adults 65+ • live in Winnipeg • medically able to participate in exercise • able to participate in an exercise program for one hour • able to participate in group exercise • the Safey Aid program will provide a tablet and/or internet access for those older adults that require it to participate in the virtual programming	Referrals can be made by contacting A&O Intake: **Email:** intake@aosupportservices.ca **Phone:** 204-956-6440 **Toll Free:** 1-888-333-3121	Safety Aid Website

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REHABILITATION (Specialized)

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Cardiac Rehab *located at Reh-Fit Centre and Wellness Institute* *'Cardiac Rehab @ Home' is also available for those unable to attend in person*	Program Features: • a 16-week rehabilitation program designed to help individuals safely return to activity after a cardiac event • includes education sessions and supervised/guided exercise • the program has a small fee, which enables full access to the facility and services; financial help may be provided, based on individual need Team Involved: • (variable by site) • PT, SW, Doctors, Nurses, Kinesiologists, Dietitians, Psychologists	Anyone with a history of: • Coronary Artery Disease - Acute Coronary Syndrome - Angina - CABG Surgery - PCI (Peri-Coronary Intervention) • Heart Failure • Cardiomyopathy • Complex Congenital Heart Diseases • Valve Disease • Arrythmias • Peripheral Artery Disease (symptomatic) • Thoracic Aortic Aneurysm *One Cardiac Rehab Program per new event/diagnosis/surgical intervention.*	Referral Form An MD signature is required on the referral form. Referrals should be faxed to the location of the client's choice - fax numbers & locations are listed on the referral form.	WRHA Cardiac Rehab Website Wellness Institue Cardiac Rehab Website Reh-Fit Cardiac Rehab Website

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REHABILITATION (Specialized)

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Community Stroke Care Services (CSCS)	Program Features: • specialized therapy that offers home & community based stroke rehabilitation for adults who have had a recent stroke • involves assessment and time-limited active rehabilitation Team Involved: • OT, PT, SLP, SW, RA, Case Coordinators	• adults eligible for WRHA Home Care • adults who have been discharged from Riverview Health Centre, Health Sciences Centre, or St Boniface General Hospital, after a stroke, and who: 1. had a mild-moderate severity acute stroke with residual functional impairments 2. can be safely supported outside of an acute or rehabilitation facility 3. require further rehabilitation where home is the best setting to address rehabilitation goals *note: referrals from other hospitals or community sites are considered as capacity permits*	CSCS Referral Form Complete the referral form. CSCS Case Coordinator (CC) determines eligibility. If a client is not eligible, the CC can make recommendations on where the client's needs can be met in the health system. **Admin Phone:** 204-940-2526 **Fax:** 204-940-6620 **CSCS Team Manager:** 204-223-7731	CSCS Fact Sheet CSCS FAQs for Health Professionals

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PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Easy Street *located at Misericordia Health Centre*	Program Features: • client-centred program aiming to assist clients to achieve their full potential by achieving their identified goals • assists clients with regaining independence in areas such as dressing, cooking, attending school or work, participating in leisure activities • includes motorized wheelchair assessments Team Involved: • PT, OT, SW, Dietitian	• adults with brain injury, stroke, long COVID, or other neurological injuries	Easy Street Referral Form Referrals are accepted from healthcare professionals involved in the client's care. **Phone:** 204-788-8158 **Fax:** 204-774-7646	Easy Street Website Easy Street Fact Sheet
Movement Disorders & Motor Neuron Disease Clinics *located at Deer Lodge Centre*	Program Features: • provides multidisciplinary specialty services to clients with a spectrum of movement disorders & motor neuron diseases • this service is available to assist in the management of movement disorders & motor neuron diseases, as well as to provide input for clients with undiagnosed disorders and/or diseases Team Involved: • PT, OT, SLP, Dietitian, Genetic Counsellor, Neurologist *note: Allied Health are only involved with clients being followed by the neurologist at the clinic*	Movement Disorder Clinic: • Clients with Parkinson's Disease and Parkinsonism, Tremor, Dystonia, Chorea, Myoclonus, Huntington's Disease, Tourette's Syndrome, Restless Leg Syndrome, and Drug Induced Movement Disorders • Clients with undiagnosed movement disorders Motor Neuron Disease Clinic: • Clients with ALS, Kennedy's Disease	Referrals must be made by a physician or nurse practitioner with referring privileges. Request for Services Form	Movement Disorders Clinic Website

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PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Outpatient Programs at Health Sciences Centre	Program Features: Includes a variety of outpatient rehabilitative services for specific populations. • Outpatient Rehab - includes Neuro (OT & PT), Spinal Cord Injury (OT & PT), Amputee (OT & PT), and Vestibular (PT) Rehab • Upper Extremity/Hands Rehab Service (OT & PT) • Outpatient Musculoskeletal (MSK) Physiotherapy (PT) • Multiple Sclerosis Clinic (OT & PT) • Assistive Technology Service (OT) • Driver Assessment Managment Program (OT) • Outpatient Rheumatology Service (OT) • Specialized Seating Service (OT) • Outpatient Burns Service (OT) • Renal Service (OT)	• referral criteria for most programs can be found on the HSC Occupational Therapy website • Please contact the PT Department if there are questions about PT Referral Criteria	Referrals can be made by physicians or allied health professionals, depending on the program. Please visit the HSC Occupational Therapy website for more information and referral forms. **Phone:** 204-787-2786 (OT) 204-787-1160 (PT)	HSC Occupational Therapy website

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REHABILITATION (Specialized)

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Pulmonary Rehab *located at Deer Lodge Centre, Misericordia Health Centre, and Wellness Institute*	Program Features: • eight-week program delivered in a group setting • offers individualized exercise programs to improve breathing and tolerance • includes education to understand lung disease, prevent infections, learn breathing and relaxation techniques, and use medications effectively • the goal of the program is to assist clients with self-management of their lung problems • the program also offers "stop smoking strategies" Team Involved: • *(variable by site)* • OT, PT, SW, RT, RA, Dietitians, Pharmacists, Kinesiologists, Respirologists	• clients with chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, pulmonary fibrosis, and long COVID • a full list of inclusion & exclusion criteria can be found here	Pulmonary Rehab Referral Form Referrals are accepted from Primary Care Providers, Home Care Coordinators, Hospital Inpatients Units and Emergency Departments Referrals are sent and distributed through the Pulmonary Rehabilitation Intake Coordinator: **Phone:** 204-831-2181 **Fax:** 204-940-8633	Pulmonary Rehab Website Pulmonary Rehab Brochure
Private PT for Post-Operative Elective Joint Replacements	Program Features: • clients who have undergone an elective hip or knee replacement can access a limited number of PT visits at private clinics throughout the province, funded by MB Health • eligible clients can receive up to six individual or ten group sessions	• clients who have undergone elective hip or knee replacements and revisions since January 1 2023 • clients who do not have private insurance, or who have exhausted their benefits and require additional PT services	Clients should contact the clinic of their choice directly to arrange for an appointment; a referral is not required but may be provided by the inpatient physiotherapist post-operatively.	Post-Operative Physiotherapy FAQ Document

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IN-HOME ASSESSMENT & CONSULTATION

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Community Therapy Services (CTS)	Program Features: • provide direct services, consultation, and education • multiple programs (outlined below) Team Involved: • PT, OT	• contact CTS Intake to discuss potential referrals to the program • **CTS Intake Phone:** 204-949-0533, ext 234	**CTS Intake:** **Phone:** 204-949-0533, ext 234 **Fax:** 204-942-1428 **Email:** cts@ctsinc.mb.ca	CTS Website
	Home Care - consultative services (OT & PT) to clients eligible for WRHA Home Care Program	• must be eligible for WRHA Home Care Program • require short-term OT/PT intervention • are not involved with or covered by other programs/resources • has identified that home/community is best environment to address needs	General CTS Referral Form • referrals that are not generated by Home Care/Hospital Based Case Coordinators should be faxed directly to **WRHA Central Intake** • clients or caregivers can phone Central Intake to initiate a CTS referral	**WRHA Central Intake** **Phone:** 204-788-8330 **Fax:** 204-940-2227
	Long Term Care - consultative services (OT & PT) in various Personal Care Homes in Winnipeg	• must be a resident of a PCH serviced by CTS	PCH PT Referral Form • the above form can be faxed to **CTS Intake** for PT services • OT referrals are generated from within the PCH	
	Support & Consultation for Independent Living (SCIL) - OT services to individuals who are living with serious mental illness and severe and persistent functional impairment	• must have serious mental health illness (diagnosed)	SCIL Referral Form • referrals can be made by WRHA Community Mental Health Program or an alternate mental health service provider, and faxed to **CTS Intake**	SCIL Website
	Fly-In Services - fly-in PT services to residents living in several First Nations communities in northern Manitoba	• must reside in a serviced area: St. Theresa Point, Wasagamack, Norway House, Percy E. Moore Hospital, Pauingassie, Bloodvein, Red Sucker Lake, Garden Hill, Berens River, Poplar River	General CTS Referral Form • referrals can be faxed directly to **CTS Intake**	Fly-In Services Website
	Community Living disAbility Services - consultative services (OT & PT) to clients who are part of the CLdS Program	• must be a recipient of CLdS	CLdS Referral Form • referrals must be made by a Community Services Worker, and faxed to **CTS Intake**	

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PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Geriatric Outreach Services *includes Geriatric Program Assessment Team (GPAT) & Geriatric Mental Health Team (GMHT)*	Program Features: • healthcare professionals who do a cross-disciplinary & multi-dimensional assessment, including recommendations from geriatric specialty physicians • assess many areas of health and day-to-to functioning, including: mobility/falls, ADLs, memory, mood, medication management, social supports, emotional & behavioral complications of brain disease • consultative services model, which provides recommendations for care providers, education, support & connection with resources	• adults 65+ • community-dwelling • live within the boundaries of the WRHA • require an in-home specialized geriatric assessment • service is non-emergent • client must be agreeable to a home visit	GPAT/GMHT Referral Form Open referral process - anyone can refer, including health care providers, community groups, families, clients. **Central Intake Phone:** 204-982-0140 **Central Intake Fax:** 204-982-0144	GPAT Information Brochure GPAT Website GMHT Information Brochure GMHT Website

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SOCIALIZATION - ENGAGEMENT - RESPITE

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Adult Day Program (ADP) *participants attend a location in their catchment area*	Program Features: • health maintenance & socialization in a supportive environment - includes planned therapeutic recreation, mental fitness, and physical fitness programs • provides respite to caregivers • participants attend once/week • meals, snacks, & transportation provided • participant fee for each day of attendance	• adults 65+ • community-dwelling • admitted to WRHA Home Care Program • social isolation, limited ability to access recreational/social activities in the community • physical frailty • potential for deterioration in function • must be able to communicate personal needs • able to participate in a group setting • able to independently transfer/mobilize and dress (with some prompts) • able to feed self with no assistance • continence managed • no physical assistance with medication management (ADP staff may provide reminders) • able to tolerate 6-8 hours of activity without exhaustion or extreme fatigue	Must be referred by Community Home Care Coordinators	Informational PPT (from Alzheimer's Society) Get Away Club Information Brochure (located at DLC) Adult Day Program Website (Simkin Centre) Rendezvous Club Brochure (located at RHC)

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PRIMARY CARE

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Access Winnipeg West	Program Features: • coordinated services of an interdisciplinary team • prioritizes clients who experience complex health issues & barriers to service Team Involved: • OT, PT, physicians, nurses, dietitians, mental health counsellors	• prioritized clients reside in the community area (Assiniboine South, St James Assiniboia, Headingley) • must not already have access to a regular Primary Care/Family Provider (Physician or Nurse Practitioner)	The clinic can be contacted directly: **Phone:** 204-940-8724 A walk-in clinic is also available, and open 7 days/week.	AWW Website
Health Services on Elgin	Program Features: • primary care and allied health services to at risk adults (age 18+) living in the Downtown & Point Douglas communities • individuals can attend the full program, or attend for focused interventions • fall prevention programming offered 2x/week Team Involved: • OT, PT, Primary Care Nurses, Footcare, Community Mental Health Worker	• adults with complex needs (> 18 years old) • living within the Downtown & Point Douglas catchment areas • willing to participate • free transportation to group sessions for participants in the catchment area • reasons for referral can include: falls, unexplained decline in function, social isolation, memory loss, behavioral changes, depression, caregiver stress	HSE Referral Form *(same referral form as for Day Hospital)* Referrals can be made by health professionals involved in the client's care, from community or from a facility/hospital.	For more information, call 204-940-1637

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PRIMARY CARE

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
My Health Teams (MyHTs) *there are six MyHTs located in Winnipeg:* 1. *Downtown/Point Douglas* 2. *St. James/Assiniboine South* 3. *Seven Oaks* 4. *River East/Transcona* 5. *St. Boniface/St. Vital* 6. *Fort Garry/River Heights* *WRHA partners with MyHTs in collaboration with participating private fee-for-service clinics. Participation with MyHTs is voluntary.*	Program Features: • provide services to connect participating primary care providers to team-base care • MyHTs adapt to the emerging needs of patients, providers, and the community area • each MyHT has a unique team composition based on the needs identified by the MyHT partners • MyHT clinicians connect patients to existing services and find a way to support patients who require alternatives • MyHT clinicians (in collaboration with other community partners) facilitate group programming *(see Health Management section for details)* Team Involved: • *(variable by site/MyHT)* • OT, PT, SW, Nurses, Pharmacists, Chronic Disease Managment Clinicians, Income & Housing Supports, Mental Health Supports	• adults 18+ • services are only available to patients of providers that participate in a Winnipeg MyHT *(note: the patient can only access the services of the MyHT that the their primary care provider is linked with)*	Referrals for MyHT services must be initiated by the patient's primary care provider Health Managment classes are open to all *(see Health Management section)*	MyHTs - Key Elements MyHTs - FAQs

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PRIMARY CARE

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Nine Circles Community Health Centre	Program Features: • expertise in the care & treatment of HIV, Hepatitis C, and other STIs • delivers comprehensive primary care, social support, education, and prevention services • services include clinical services, health promotion, services for those living with HIV, community education, harm reduction Team Involved: • OT, SW, Dietician, Pharmacist, Nurses	• individuals 13+ who live in Winnipeg and meet one or more of the following criteria: 1. belong to a population that tends to have higher rates of HIV infection 2. have a history of substance use disorder 3. are at risk for having poor health outcomes 4. live in the Downtown-Point Douglas area of Winnipeg	Nine Circles Referral Form Nine Circles Appointment Booking Information	Nine Circles Website
Northern Connections Medical Centre (NCMC) *located within Seven Oaks Hospital, with satellite location at 425 Elgin Avenue*	Program Features: • provides primary care for clients residing in the Downtown/Point Douglas community area, as well as individuals frequently back & forth between Winnipeg and northern Manitoba communities • home of the UofM Northern/Remote Family Medicine Residency Program Team Involved: • OT, PT, SW, Family Medicine Physicians & Residents, Nurses, Dietitians, Pharmacists	• any clients with a primary care provider at NCMC • accepts clients that are temporarily in Winnipeg from northern communities, military families posted in Winnipeg, and First Nation individuals living in Winnipeg that do not have a primary care provider (e.g., medical relocation patients, Cancer Care patients, mental health patients, require a provider that has knowledge of cultural safety)	Internal referrals from NCMC Providers are generated through Accuro. Referrals also accepted from MyHT, HART, Home Care Case Coordinators, Community Mental Health, community care providers, self-referrals. **Phone:** 204-940-8777	

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HEALTH MANAGEMENT

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Health Management Group Programs *live, online, or pre-recorded group sessions*	Program Features: • health management and chronic disease management courses are offered by interdisciplinary members of the MyHTs and other community partners • topics include: COPD, smoking cessation, Long COVID, Diabetes Management, and Physical Activity Essentials	• programs are free of charge, and can be accessed by anyone in the province though the Health Managment Group Program website	No referral required. Patients can self-register.	Health Management Group Program Guide

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COMMUNITY SUPPORT

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
A&O: Support Services for Older Adults	Program Features: • provides specialized services for older Manitobans across the province • empowers & supports older adults in the community, with services under 3 Pillars: 1. Safety & Security (programs include elder abuse prevention services, safe suite program, older victim services, Safety Aid, This Full House) 2. Social Engagement (programs include Senior Centres without Walls, Connect Program, Senior Immigrant Settlement Services) 3. Counselling Services (programs include counselling, information & referral, intake, Caregiving with Confidence, housing, legal services)	• older adults (55+) who are looking to improve quality of life in the community	Contact the intake line: **Intake Email:** intake@aosupportservices.ca **Intake Phone:** 204-956-6440	A&O Website
City of Winnipeg Social Workers (Community Crisis Workers)	Program Features: • SW available for one-on-one appointments • can provide information about shelter & housing, social assistance, jobs, counselling, mental health programs & services, health care, income tax	• anyone accessing Millenium Library	Schedule appointments online: Community Crisis Worker Appointment Scheduler Drop-in appointments also available, and individuals can access events hosted by the Community Crisis Workers.	Community Crisis Worker Website Community Connections Event Calendar

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COMMUNITY SUPPORT

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Emergency Paramedics in the Community (EPIC)	Program Features: • operated by Winnipeg Fire & Paramedic Service, and staffed by paramedics • provides early health assessments & intervention planning to Winnipeg patients who are identified as top users of Emergency Medical Services (EMS) and Emergency Department Services • operate two teams • connection with HIV patients	• individuals who frequently access Emergency Services • individuals who would have an at-risk referral from EMS when they arrive on scene	Service providers may contact EPIC teams directly: **EPIC 1:** *(operates out of Main Street Project, 75 Martha Street)* 204-918-2758 **EPIC 2:** 204-330-4612 **Email:** KarenMartin@winnipeg.ca	
Healthy Aging Resource Team (HART) . *there are three HART teams located in Winnipeg:* 1. *Downtown/Point Douglas* 2. *St. James/Assiniboine South* 3. *River East/Transcona*	Program Features: • community-based healthcare professionals dedicated to helping those age 55+ live well • provide a wide range of health services and community supports through client assessments and consultations (in person and by phone) • help individuals find & connect with resources, maintain & improve their health, provide information about health services, learn about healthy living Team Involved: • OT, PT, SW, Dietitians, Nurses	• HART can help anyone 55+, residing in the community area they serve	Individuals can self-refer, or referrals can be made by health care professionals & service providers. HART Referral Form	HART Website HART Informational PDF *Note: the website & pamphlet are geared towards clients; the HART referral form has information on page 2 directed to health care professionals and referral sources.*

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COMMUNITY SUPPORT

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Health Outreach Community Supports (HOCS)	Program Features: • clinical consultation, with a focus on access to health & social services for individuals who are: 1. experiencing homelessness and do not have a strong circle of support 2. experiencing homelessness, have a strong circle of support, and are still struggling Team Involved: • OT, SW, NP	• individuals who are homeless or unstably housed and have barriers to accessing health services • individuals who frequently access emergency services	Service providers may contact HOCS team members directly: **Shannon Watson** ***(Manager):*** swatson5@wrha.mb.ca **Lukas Maitland** ***(Clinical Coordinator):*** lmaitland@wrha.mb.ca **Tammy Rowan** ***(Clinical Team Coordinator):*** trowan@wrha.mb.ca	
Jewish Child & Family Services (Older Adult Services)	Program Features: • specialized services to the Jewish elderly • support, empower, and advocate for older adults so they many continue to live independently in the community • programs include individual counselling, information & referral, advocacy, volunteer services, support groups, outreach, technology for seniors • also offer specialized services including support services for Holocaust survivors, newcomer seniors integration services, and aging mental health	• older adults who identify as Jewish	Call to book an appointment **Phone:** 204-477-7430	Jewish Child & Family Services OAS Website

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COMMUNITY SUPPORT

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Klinic Community Health	Program Features: • provides a full range of health-related services • healthcare/medical services (team-based medical care, drop-in services, specialized services) • crisis support (clinical crisis line) • counselling services (drop-in, family violence, trauma, sexual assault) • wellness & support groups • transitioning care health clinic	• individuals that are 13+ • tranisitioning care clinic - 16+	**Reception:** 204-784-4090 **Medical Intake:** 204-784-4059 **Counselling Intake:** 204-784-4059 **Wellness & Support Groups:** 431-478-0280 Klinic Contact Info	Klinic Website

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PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
PRIME Program *located at Deer Lodge Centre & Misericordia Health Centre*	Program Features: • long term program providing care to seniors with chronic complex problems posing risk of admission to Personal Care Home, Emergency Depts and/or hospital • provides a maintenance focus for clients who no longer have rehab potential • clients attend the program 1-5x/week • services include primary health care, medical care from a physician and/or nurse practitioner, home care case coordination, assessment & treatment by a multi-disciplinary team • after hours support provided by a nurse to prevent ED visits Team Involved: • *(variable by site)* • OT, PT, SW, Dietitians, Pharmacists, Nurses, Recreation Facilitators	• adults 65+ • reside in the Winnipeg community • high risk of requiring Personal Care Home placement • clients must be willing to work with the PRIME associated physician (with a transfer of care from their family physician to the PRIME program)	PRIME Referral Form For information or referrals: **Phone:** 204-833-1700 **Fax:** 204-940-2125	PRIME Website PRIME Brochure

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PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Supports for Seniors	Program Features: provides a variety of services & resources, including: • Senior Resources Finder • Tenant Resource Coordinators • Congregate Meal Programs • Senior Centres • Supports to Seniors in Group Living • A&O: Support Services for Older Adults • Alzheimer's Society of Manitoba • Canadian National Institute for the Blind • Conseil des Francophone (Bilingual Senior Resource Finder) • Creative Retirement Manitoba • Indigenous Seniors Resource Centre • Meals on Wheels Winnipeg • Rainbow Resource Centre	• older adults (age 55+) • some programs (e.g. Meals on Wheels) may be accessed by individuals under 55 years of age	Varies based on programming - contact the service area for specific referral processes (see website). **Kathy Henderson *(WRHA Seniors Care Specialist)*:** khenderson@wrha.mb.ca	Support Services to Seniors Website Support Services for Seniors Framework

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	PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
COMMUNITY SUPPORT	**Vulnerable Persons Unit**	Program Features: • provide follow-up visits, usually from frontline police-officer's reports • take referrals for cases that are non-criminal and involve individuals 18+ • partnership between Police Services and Community Services departments	• older adults living with mental illness, dementia, hoarding, financial abuse	Contact a constable to discuss concerns/what is occurring. **Phone:** 204-986-6287	
INDIGENOUS SUPPORT	**WRHA Indigenous Health**	Program Features: • supports holistic needs of First Nations, Metis, and Inuit people • works with regional programs & facilities to help identify, develop, and implement culturally safe environments, practices, and services • provides a range of services for staff, community members, patients, and patients' families through its Patient Services, Workforce Development, and Cultural Initiatives programs.	• Indigenous individuals accessing the healthcare system within WRHA	Indigenous Health Referral Form **Phone:** 204-940-8880 **Toll-Free:** 1-877-940-8880 **Fax:** 204-943-1728	WRHA Indigenous Health Website Indigenous-Specific Health Navigation Supports Indigenous Cultural Healing and Mental Health Supports Navigating FNIHB/NIHB Transportation Referral Unit (TRU)

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CRISIS SUPPORT

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Crisis Stabilization Unit	Program Features: • provides short-term, community-based care & treatment for individuals in psychiatric or psychosocial crisis who may be at risk of hospitalization • short term crisis intervention • mental health assessment & psychosocial assessment • supportive place for an individual in crisis • therapeutic group programming • management of medications • health education regarding mental illness, coping strategies, wellness recovery planning, preventative techniques • liaison & referral to community resources • support to family members & others concerned • psychiatric consultation & assessment	• adults residing in Winnipeg who are experiencing a mental health or psychosocial crisis • individuals may have an overlapping substance use, addiction, or gambling addiction • referrals are welcome from mental health-care professionals working in crisis services, community (e.g. PACT), and hospital	Referral form (available at most sites/EDs, not available online) **Phone:** 204-940-3633 (then press 2) Staff are available 24 hours a day, 7 days a week	Crisis Stabilization Unit Website

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CRISIS SUPPORT

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Crisis Response Centre (CRC)	Program Features: • central point of access for adults experiencing a mental health crisis • accessible 24 hours a day, 7 days a week • includes integrated mental health assessments, crisis intervention, mental health crisis treatment, linkages to key resources for mental health & addiction, follow-up, individual and family peer support • offer treatment & support services through walk-in, virtual, telephone, mobile, and post-crisis appointments & classes • NOTE: clients may need an ER to manage mental health concerns if they have a warrant under the Mental Health Act Team Involved: • Crisis Clinicians & Nurses, PAs, Psychiatry, Crisis Workers, Attendants, Peer Support	CRC is specifically designed for individuals experiencing the following: • personal distress and the risk of potential harm associated with an immediate crisis, including suicidal behaviour • signs & symptoms of a condition requiring urgent mental health assessment & treatment • intense emotional trauma where assessment, crisis intervention, and linkage to other services can occur • an immediate risk after hours when the ongoing mental health service provider is not available	No referral required. Patients can present in person at **817 Bannatyne Ave**, Winnipeg. To determine if CRC is the correct resource, contact Mobile Crisis. **Phone:** 204-940-8174 Telehealth assessments services are provided throughout Manitoba.	Crisis Response Centre Website

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CRISIS SUPPORT

PROGRAM	FEATURES	REFERRAL CRITERIA	REFERRAL PROCESS	WEBSITE / INFO
Klinic Community Health	Program Features: Provides a full range of health-related services: • crisis support (clinical crisis line) • sexual assault crisis counselling *See 'Community Support' section for full range of Klinic services.*	• individuals that are 13+	**24/7 Klinic Crisis Line:** 204-786-8686 **Toll Free Crisis Line:** 1-888-322-3019 **24/7 Sexual Assault Crisis Line:** 204-786-8631 **Toll Free Sexual Assault Crisis Line:** 1-888-292-7565	Klinic Crisis Support Website Klinic Sexual Assault Crisis Website Other Crisit Support Lines
Mobile Crisis Service	Program Features: Provides services to individuals experiencing a mental health or psychosocial crisis: • mental health & psychosocial assessment • telephone consultation & support • health education • liasion & referral to community resources • support to family members & other concerned individuals • psychiatric consultation & assessment • short-term follow-up Team Involved: • Crisis Clinicians & Nurses, PAs, Psychiatry, Crisis Workers, Attendants, Peer Support	• adults residing in Winnipeg who are experiencing a mental health or psychosocial crisis • the Mobile Crisis Unit will attend locations within Winnipeg city limits	Calls or referrals are welcome from anyone who is concerned about a person experiencing a mental health or psychosocial crisis, including self-referrals and referrals from family members. Staff are available 24 hours per day, 7 days per week. **Phone:** 204-940-8174	Mobile Crisis Service Website

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